

Minutes of the meeting of the Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System held Tuesday, June 24, 2014 at the hour of 10:30 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Collens called the meeting to order.

Present: Chairman Lewis M. Collens and Directors Luis Muñoz, MD, MPH and Wayne M. Lerner (3)

Directors Ada Mary Gugenheim and Carmen Velasquez

Mr. Patrick T. Driscoll, Jr. (non-Director Member)

Absent: None (0)

Additional attendees and/or presenters were:

David Barker, MD – Ruth M. Rothstein CORE
Center of Cook County
Krishna Das, MD – System Chief Quality Officer
Anwer Hussain, MD – Provident Hospital of Cook
County
Randolph Johnston –System Associate General
Counsel

Elizabeth Reidy – System General Counsel
Deborah Santana – Secretary to the Board
John Jay Shannon, MD – Interim Chief Executive
Officer and Chief of Clinical Integration
Robert Weinstein, MD – Chairman, Department of
Medicine

II. Public Speakers

Chairman Collens asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

III. Report from System Chief Quality Officer

A. Regulatory and Accreditation Updates

B. Publicly Reported Ratings

Dr. Krishna Das, System Chief Quality Officer, stated that she had no new regulatory or accreditation issues to report.

Dr. Das stated that, with regards to the recent Ambulatory survey by representatives of The Joint Commission, evidence of standards of compliance have been submitted; they will need four months of monitoring before they hear the final determination about the certification. She added that staff is still waiting and actively preparing for Provident Hospital's triennial visit from The Joint Commission.

III. Report from System Chief Quality Officer (continued)

C. Key Quality Indicators Report: FY2014 – 1st Quarter (Attachment #1)

Dr. Das provided an overview of the Key Quality Indicators Report. The Committee reviewed and discussed the information.

During the discussion of the information regarding the Emergency Department (ED) Arrival to Admission inpatient data, Director Lerner asked whether the Centers for Medicare and Medicaid Services (CMS) allows for that line to be cut down by cohort of patients, if the patients were staged or ranked; additionally, he inquired whether the System cuts back that information to look at the cohort of patients. Dr. Das responded affirmatively. The administration particularly looks at the wait time to provider data, because it is felt that once the patient is in the hands of the ED providers, they are in a safer environment and there is very close monitoring. In terms of ED arrival to admission times, the administration can look at the data by acuity - most of these patients have higher levels, and for these patients, if there are longer waits, it is either related to bed availability or ED testing, so that data can be shown. She stated that, the point is, when the patient is in the ED, they are already receiving inpatient care; because of the long waits in the ED and the need to initiate care, the inpatient teams actually go down to the ED and collaborate with the ED staff to start inpatient care.

Chairman Collens noted that the Trauma Unit has its own admissions function, separate from the ED; he asked for further information on an example of a patient seen in the Trauma Unit who is quickly transferred to admissions. Dr. Das responded that when someone enters the Trauma Unit, they are essentially admitted almost immediately. They are within the Trauma Unit, receiving all types of care, even intensive care; they may have gone to the operating room and come back to the unit, but during that entire time, because of the type of admission, they are classified as observation patients. In that setting, during that time where all kinds of very high level medical care was delivered, the patient is still considered officially not admitted. The administration is having discussions to see if the Trauma Unit's administrative staff could do whatever it takes in the system to put the patients in a different status – that would be how the ED Arrival to Admission numbers would decrease. There is nothing staff can do to optimize or enhance the care provided in the Trauma Unit, because staff is already providing an extremely high level of care in a very short time period.

Director Muñoz inquired regarding the percentage of Trauma Unit patients versus regular ED patients. Dr. Das stated that, in any given data set of 100 ED and Trauma Unit patients, there are approximately 3 to 5 Trauma Unit patients (or 3-5%), which is not a large number of patients; however, the Trauma Unit patients are really outliers in terms of their times, and that has contaminated the whole data set.

Director Lerner inquired whether the System utilizes the concept of huddles, which is a group of multidisciplinary professionals that come together on the patient's care. Dr. Das responded that this is an initiative that has been rolled out in the Ambulatory clinics. On the inpatient side, for a couple of years now, interdisciplinary rounds have been held on the general Medical/Surgical Units; additionally, all of the Intensive Care Units have interdisciplinary rounding as a standard. Director Lerner inquired whether those currently involve the patient or the patient's family. Dr. Das responded in the negative. Director Lerner stated that this might be something to consider, as he has found that to be effective for patients with chronic disease; it also works with patients with acute problems. Dr. Das indicated that there is widespread interest in that.

III. Report from System Chief Quality Officer (continued)

C. Key Quality Indicators Report: FY2014 – 1st Quarter

In response to Director Gugenheim's question regarding staffing levels for Dr. Das' department, Dr. Das stated that the department is growing. She currently has the following staff: one staff member at Provident, three staff members within the ACHN clinics, two Assistant Directors (one who manages data and one who abstracts data). She noted that most hospitals this size have between four and six persons who only abstract data. She added that she has two positions that are currently in recruitment for quality data abstraction, so when those positions are filled, she will have three people performing that function. Dr. John Jay Shannon, Interim Chief Executive Officer and Chief of Clinical Integration, provided additional information. He stated that there is an organizational philosophy connected to that subject. There is no question that the infrastructure for quality is strategic and the organizational awareness piece needs to be amped-up; however, the misconception that he wants to avoid is that the Quality Department *produces* quality for the organization - it is 100% across-the-board organizational ownership of the production of quality. The Quality Department can only support, guide and give a little bit of supporting function to that.

D. Quality Report – Ruth M. Rothstein CORE Center of Cook County (Attachment #2)

This item was taken out of order.

Dr. David Barker, Chief Medical Officer of the Ruth M. Rothstein CORE Center of Cook County, provided an overview of the CORE Quality Report. The Committee reviewed and discussed the information.

During the discussion of the information on viral suppression, Director Lerner inquired whether there has ever been a study on the social cost benefit for those patients whose viral load is suppressed and who remain engaged in ongoing care. From a public health policy point of view, he stated that what one would want to look at is the social cost benefit of doing this kind of treatment and outreach - how many people does CORE get to the viral suppression stage and who are back in the workforce, producing economic development, gainfully employed, those kinds of things. If a study on the social cost benefit is done, it shows the validity of going through this process, and it gives standing to the people who are policymakers to continue to fund this. Dr. Barker responded that there are quite a bit of data about cost effectiveness of HIV care. The current annual cost of treating someone who has reasonable CD4 counts is about \$17,500 per year, which is well within the range of what is considered cost effective. The years of additional life gained through HIV care are essentially currently unbounded; as the average age of patients receiving care is 35, the patient is so far below median mortality, which is what is needed in the Kaplan Meier assessment to calculate mortality, that one really cannot tell how many years are being added to people's lives. The Danes did a very good study on this subject; they found that the Danish patients who came to clinic and took their medications have a longevity that is indistinguishable from Danes who are not HIV infected. He added that Denmark has a national health system and that everybody has access to the care and medications.

Dr. Barker stated that HIV care is definitely a winner, in terms of cost effectiveness, quality-adjusted life years, and gaining the quality of life for these patients that improves markedly - they stop losing weight, are less fatigued, and feel better.

Director Lerner encouraged the administration to consider this subject as a focus for a public relations story in the future. A reporter might want to follow some patients and talk about the policy implications of this kind of intervention. He stated that the public does not understand it; additionally, there is a fear factor, so this is another way of getting the message across.

III. Report from System Chief Quality Officer

D. Quality Report – Ruth M. Rothstein CORE Center of Cook County (continued)

Director Gugenheim stated that this is an amazing success story of the medical home concept and successful handling of a population's health; she added that it is the model of what the System should be doing for every diagnosis.

Chairman Collens thanked Dr. Barker and staff for the report. He also recognized and thanked Dr. Robert Weinstein, Chief Operating Officer of the Ruth M. Rothstein CORE Center, who will be transitioning into a different role at the end of the month.

Dr. Shannon provided additional comments on the subject. He stated that many people in the organization are aware that Dr. Weinstein will be transitioning at the end of the month – he is not leaving the organization, but is stepping down from a couple of his formal leadership positions in the Department of Medicine. He has been with the organization for 20 years. He first arrived as the Chief of Infectious Diseases in 1994. He led the CORE Center from 1998, when it opened in its new facility until the present time, and has been the Chairman of the Department of Medicine since 2008. At the end of this month, he will transition into voluntary status and will continue to be very engaged with the organization. Dr. Shannon wanted to recognize him for a number of things, but most importantly, for the features of a leader – features that include strategic thinking, taking responsible action, and attracting and mentoring a whole cadre of dedicated individuals.

Dr. Shannon stated that, in addition, he thinks that it is very important to point out the good quality results that Dr. Barker presented. At the CORE Center, one can see the development of the tripartite mission that the System has tried to accomplish throughout its history; it is around patient care, but also around teaching and around discovery. Those are very important and cannot be overemphasized.

Dr. Shannon noted that two-thirds of what happens in the CORE Center comes in with extramural dollars; it does not cost the County taxpayer anything over and above that degree of federal dollars that come in through that extramural funding. In addition to that, Dr. Weinstein and the team in HIV services have demonstrated a remarkable stewardship. The providers and the team at the CORE Center think about how they are at an inflection point with the way that the country is looking at how to take care of HIV infected individuals. That will have significant effects, as many patients transition off Ryan White funding, which is the funding of last resort, to other forms of coverage, including the Medicaid expansion. That will have very real financial implications for the bottom line of the Medicaid Managed Care plan. The good news is that the previous track record of engagement of those leaders bodes well for the organization. They are going to help think through how to make that transition happen in a way that works for the patients and the System.

Dr. Shannon referenced Director Gugenheim's earlier comment regarding the CORE Center being a model for the patient-centered medical home concept. He stated that many of the things that are being currently discussed relating to the patient-centered medical home are exactly analogous to the care provided over the years at the CORE Center - wrap-around and supportive services, integration of behavioral health, integration of dental health and spiritual support of the individuals. The challenge for the organization is going to be around scale. As Dr. Barker mentioned, there are approximately 4,000-5,000 individuals in chronic care at the CORE Center; in adult primary care, there are approximately 100,000 within the System right now, and there was recently an infusion of an additional 65,000 adults.

III. Report from System Chief Quality Officer

D. Quality Report – Ruth M. Rothstein CORE Center of Cook County (continued)

With regard to the transition for the CORE Center, Dr. Shannon stated that the current Chief of Infectious Diseases, Dr. David Schwartz, will become the Director of the CORE Center. Dr. Barker will continue in his leadership role as the Medical Director for the CORE Center. Clinical operations with the CORE Center, which is a recognized and important part of the System's Ambulatory Services, will be under the leadership of Kathi Braswell.

IV. Action Items

A. Minutes of the Quality and Patient Safety Committee Meeting, May 27, 2014

Director Lerner, seconded by Director Muñoz, moved to accept the Minutes of the Quality and Patient Safety Committee Meeting of May 27, 2014. THE MOTION CARRIED UNANIMOUSLY.

B. **Medical Staff Appointments/Re-appointments/Changes** (Attachment #3)**

Director Lerner, seconded by Director Muñoz, moved to approve the medical staff appointments/reappointments/changes. THE MOTION CARRIED UNANIMOUSLY.

C. Any items listed under Sections IV, V and VI

V. Recommendations, Discussion/Information Items

A. Reports from the Medical Staff Executive Committees

- i. Provident Hospital of Cook County**
- ii. John H. Stroger, Jr. Hospital of Cook County**

Dr. Ozuru Ukoha, President of the Executive Medical Staff (EMS) of John H. Stroger, Jr. Hospital of Cook County, was unable to attend the meeting due to a work-related conflict that arose.

Dr. Anwer Hussain, President of the Executive Medical Staff (EMS) of Provident Hospital of Cook County, presented his report. He stated that he wanted to compliment the HIV and Infectious Disease staff. As a clinician in the Emergency Department, he has come across quite a few newly-diagnosed HIV patients; without hesitation, he stated that everyone will agree it that they have a very efficient way of getting patients into the clinics. He thanked Dr. Weinstein, Dr. Barker and staff.

VI. Closed Meeting Items

A. **Medical Staff Appointments/Re-appointments/Changes****

B. Litigation Matter(s)

The Committee did not recess the open meeting and convene in a closed meeting.

VII. Adjourn

As the agenda was exhausted, Chairman Collens declared that the meeting was
ADJOURNED.

Respectfully submitted,
Quality and Patient Safety Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Lewis M. Collens, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

Cook County Health and Hospitals System
Quality and Patient Safety Committee Meeting Minutes
June 24, 2014

ATTACHMENT #1



Key Quality Indicators

Quarter 1 2014 Report

Cook County Health and Hospitals System

Quality and Patient Safety Committee

Cook County Health and Hospitals System Board of Directors

June 24th 2014



Inpatient Services

John H. Stroger, Jr. Hospital
Provident Hospital

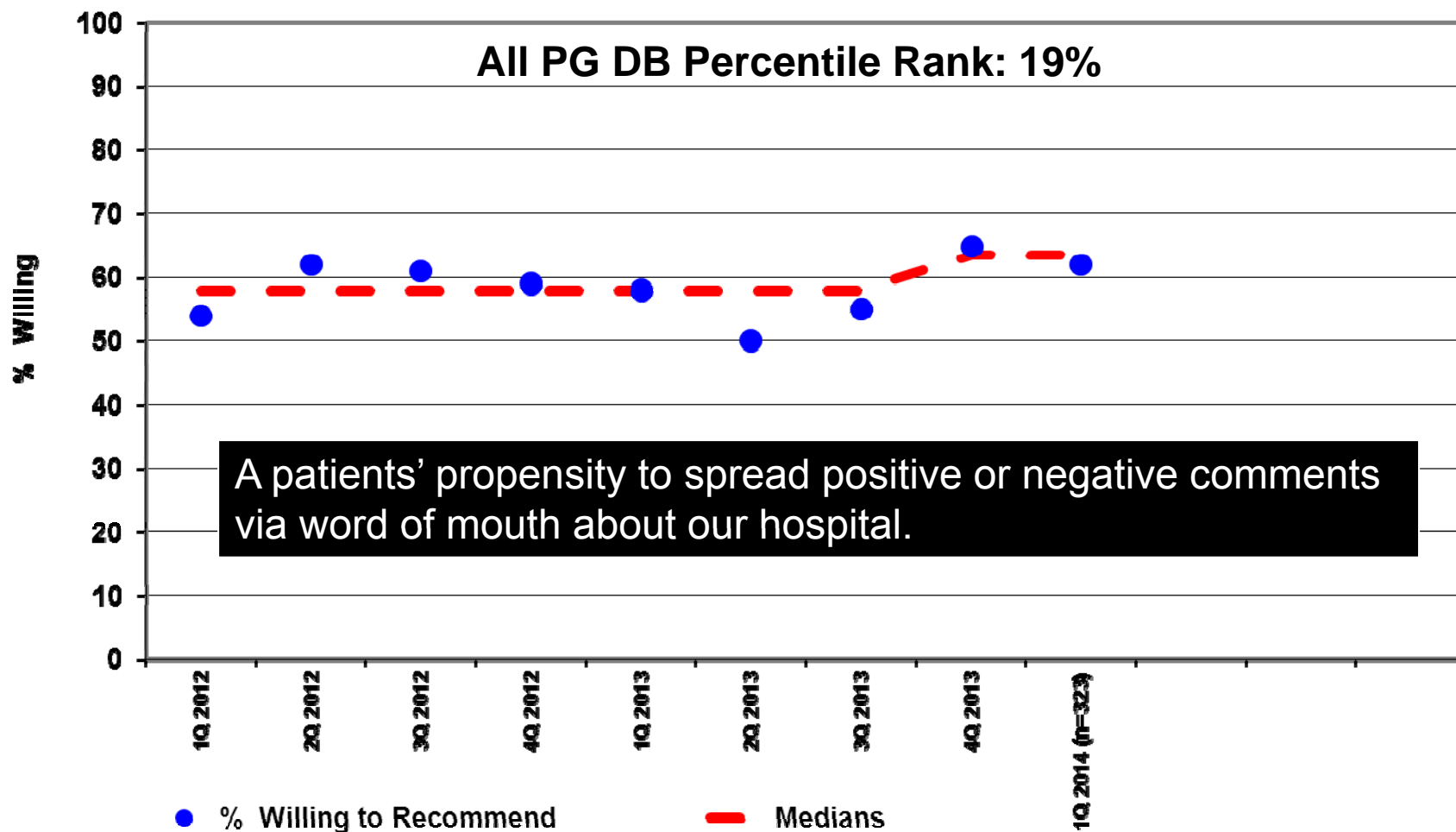
Inpatient Services – Operational Efficiencies

Indicator	FY 2013 Q3	FY 2013 Q4	FY 2014 Q1	2014 Target
Stroger Hospital				
Emergency dept. volume	34,818	32,775	30,217	-
ED Wait to be seen (minutes)	140	126	82	120
ED Arrival to Admission (inpatient)	620	457	536	480
ED Arrival to Discharge (outpatient)	366	252	242	240
% Left w/o being seen (LWBS)	9.3%	7.8%	6.1%	8%
Provident Hospital				
Emergency dept. volume	9,340	8,804	7,893	-
ED wait to be seen (minutes)	108	89	109	120
ED Arrival to Admission (inpatient)	616	631	658	480
ED Arrival to Discharge (outpatient)	218	223	225	240
% Left w/o being seen (LWBS)	8.6%	7%	6.1%	8%

Inpatient Services – Patient Satisfaction

Affiliate/ Indicator	CY 2013 Q3	CY 2013 Q4	CY 2014 Q1	2014 Target
Stroger Hospital				
% Patients 'definitely' recommend this hospital	61%	65%	62%	70%
%ile Rank, 'definitely' recommend	15 th	25 th	19 th	50 th
Provident Hospital				
% Patients 'definitely' recommend this hospital	58%	68%	68%	70%
%ile Rank, 'definitely' recommend	10 th	33 th	34 th	50 th

Patient Experience: Willing to Recommend Global Question Scale 0 - 10



Improving Patient Experience- An Overview

- Ensure leaders are engaged and fully supportive
 - Convene a steering committee to provide immediate leadership for this effort
 - Recruit a Director of Patient Experience
- Ensure that an integrated, system-wide approach is used to improve the patient experience
 - Utilize consistent communication strategies
 - Plan system-wide service behavior optimization programs
 - Develop a framework for management accountability for the patient experience
 - Utilize proven strategies to improve service recovery and patient experience

Priority Index – A Guide to Improvement

INPATIENT REPORT

9.0 Priority Index (Internal)

The Internal Priority Index combines information about your hospital's performance and the relative importance of each question to respondents' overall satisfaction. Higher priority is given to those issues that are relatively important to respondents (high correlation coefficients) and that you scored low on (low mean scores). Questions are listed in decreasing priority. Pay particular attention to questions that are consistently among your top ten priorities. ***Questions that are among this period's top ten priorities appear in bold italics in this and previous sections of the report.***

Current Order	Previous Order	Periods Top 10	Question	Mean Score	Correlation Coefficient	Priority Index	
1	3	19	<i>Staff addressed emotional needs</i>	75.3 (32)	.77 (32)	32	32 64
2	2	19	<i>Response concerns/complaints</i>	76.7 (30)	.77 (31)	30	31 61
2	4	19	<i>Attention to special/personal needs</i>	80.1 (23)	.80 (38)	23	38 61
4	7	11	<i>Wait time for test or treatments</i>	71.5 (37)	.69 (19)	37	19 56
4	14	1	<i>Staff include decisions re:trtmnt</i>	80.2 (22)	.78 (34)	22	34 56
6	5	4	<i>Nurses' attitude toward requests</i>	81.0 (17)	.78 (35)	17	35 52
7	17	1	<i>Staff attitude toward visitors</i>	82.5 (12)	.81 (39)	12	39 51
8	1	19	<i>Nurses kept you informed</i>	80.6 (20)	.76 (30)	20	30 50
8	5	2	<i>Explanations:happen during T&T</i>	79.5 (25)	.73 (25)	25	25 50
8	8	2	<i>Accommodations & comfort visitors</i>	79.8 (24)	.73 (26)	24	26 50

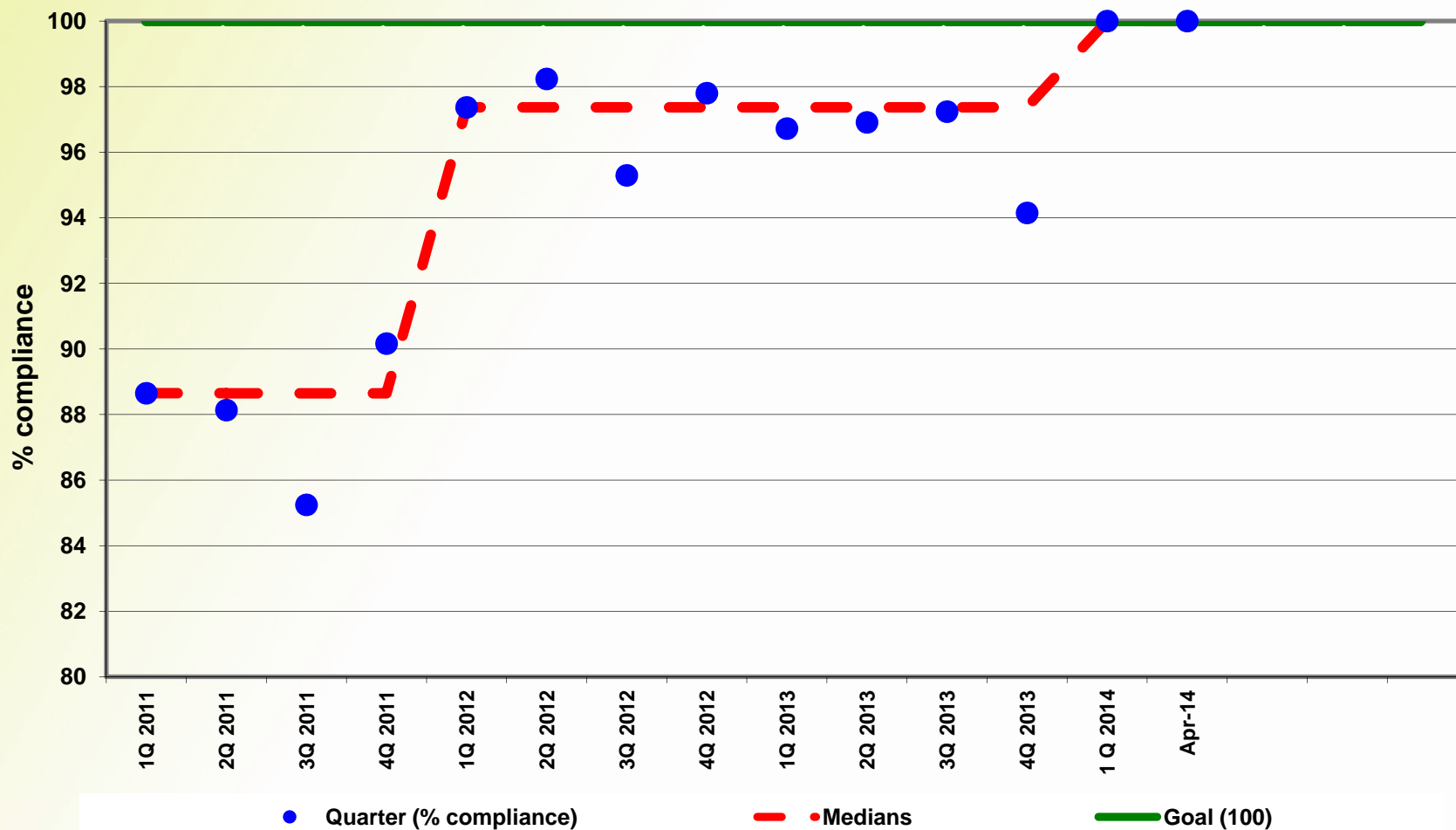
Improving Patient Experience- Specific Approaches

- Develop unit specific/ area specific evidence based strategies to improve the perception of care and satisfaction with care:
 - Bedside shift reports
 - Bedside shift reports
 - White boards/ communication boards
 - Physician communication interventions
 - Service recovery strategies for wait times and delays
- Develop a robust and sustainable rewards and recognition program
- Leadership rounds

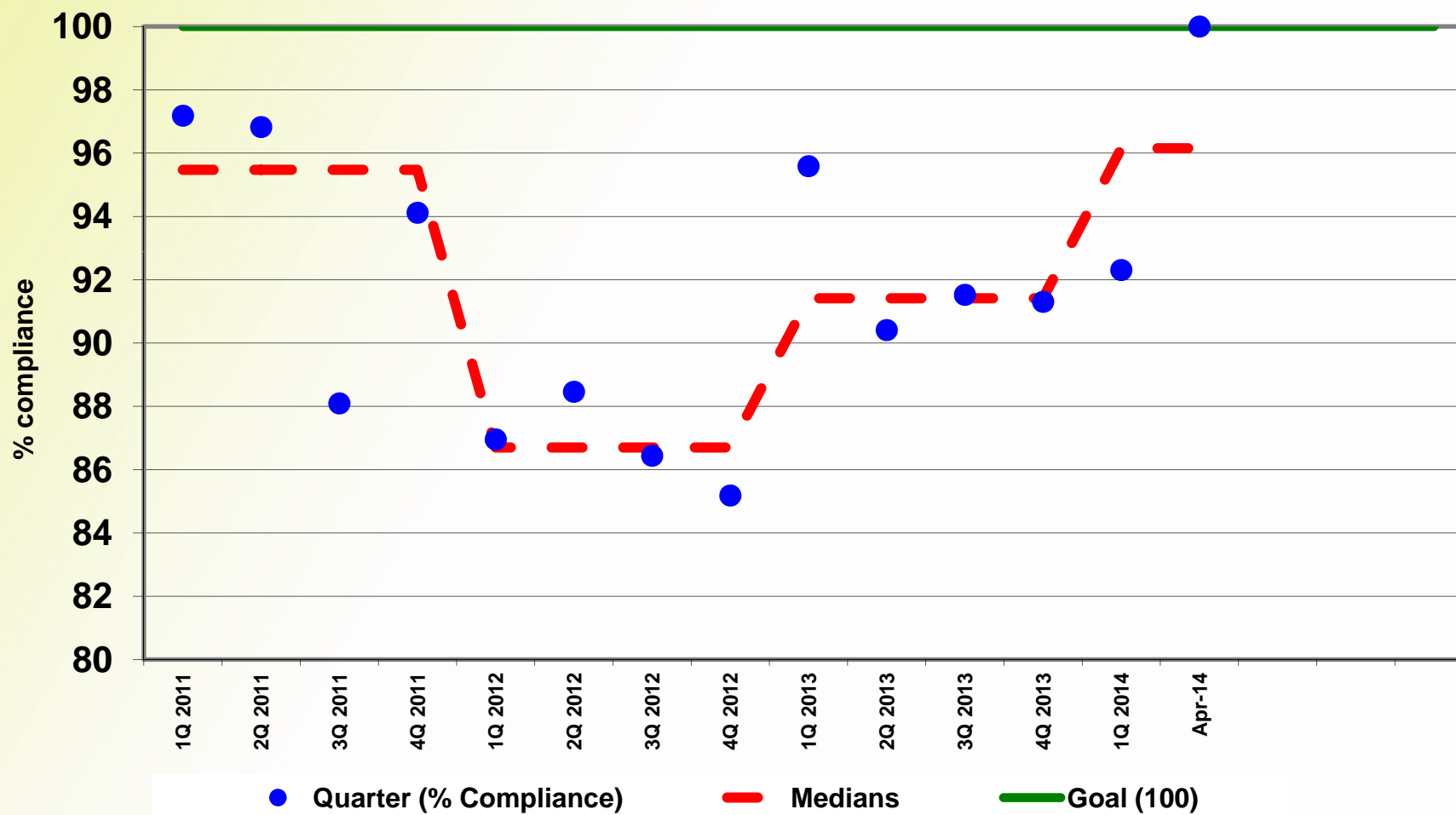
Inpatient – Quality of Care

Affiliate/ Indicator	CY 2013 Q2	CY 2013 Q3	CY 2013 Q4	CY 2014 Q1	2014 Target
Stroger Hospital					
Myocardial Infarction	98%	98%	99%	99%	100%
Heart Failure	97%	97%	98%	100%	100%
Pneumonia Care	89%	92%	92%	94%	100%
Surgical Care	98%	99%	99%	99%	100%
Provident Hospital					
Myocardial Infarction	na	na	na	na	100%
Heart Failure	92%	100%	100%	99%	100%
Pneumonia Care	83%	91%	92%	96%	100%
Surgical Care	99%	97%	100%	100%	100%

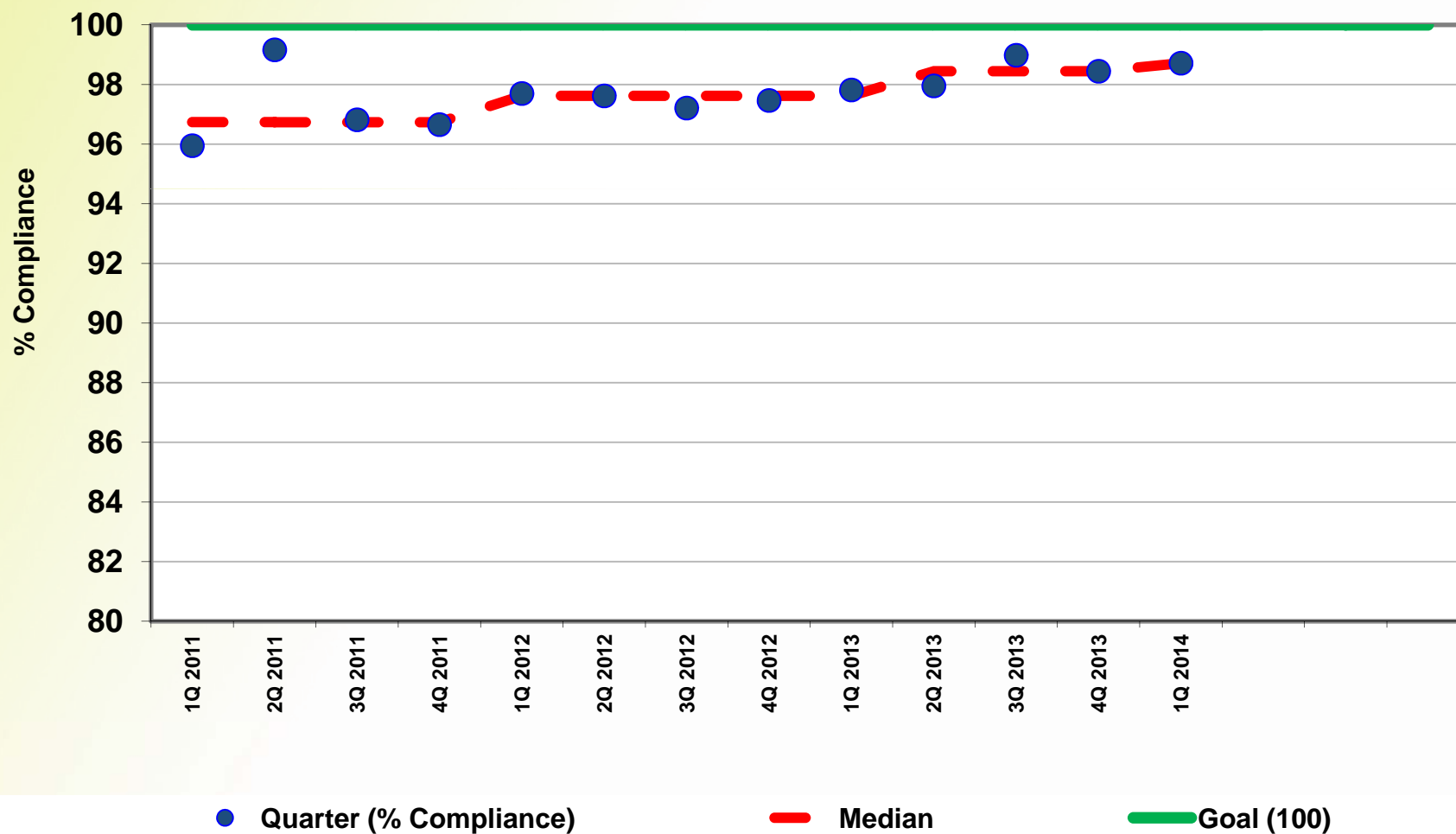
Heart Failure Composite Score



Pneumonia Composite Score



Surgical Improvement Project (SCIP) Composite Score



Quality Data Display -- Cerner Lighthouse

ip Pneumonia 4.3 Detail

Facility: All

Report | 01/01/2014 - 03/31/2014

Last Re ##

Filters Applied During Drill:

Page Nr 1

Total Pz 1

NHIQM 4.3

Patient Information

Quality Indicators

P A T I E N T · D E T A I L S	Attending Physician		Discharge Facility	Discharge Nurse Unit	Discharge Date	Sample Month	PN-3a	PN-6	PN-6a	PN-6b
	P H Y S I C I A N · I N F O		PROV	PROV 8WST	1/19/2014	JANUARY	Excluded	Met	Excluded	Met
			PROV	PROV 8WST	2/12/2014	FEBRUARY	Excluded	Met	Excluded	Met
			Stroger	6 South	1/1/2014	JANUARY	Met	Excluded	Excluded	Excluded
			Stroger	6 South	3/26/2014	MARCH	Excluded	Met	Excluded	Met
			PROV	PROV 8WST	1/16/2014	JANUARY	Excluded	Met	Excluded	Met
			PROV	PROV 8WST	1/23/2014	JANUARY	Excluded	Met	Excluded	Met
			PROV	PROV 8WST	3/13/2014	MARCH	Excluded	Met	Excluded	Met
			PROV	PROV 8WST	1/20/2014	JANUARY	Excluded	Met	Excluded	Met
			PROV	PROV 8WST	1/6/2014	JANUARY	Excluded	Met	Excluded	Met
			Stroger	6 West	2/18/2014	FEBRUARY	Excluded	Met	Excluded	Met
			Stroger	8 East	1/3/2014	JANUARY	Met	Met	Met	Excluded
			Stroger	7 South	3/7/2014	MARCH	Met	Met	Met	Excluded
			Stroger	6 South	1/8/2014	JANUARY	Excluded	Met	Excluded	Met
			Stroger	6 East	2/14/2014	FEBRUARY	Excluded	Met	Excluded	Met
			Stroger	8 South	1/18/2014	JANUARY	Met	Excluded	Excluded	Excluded
			Stroger	6 West	3/26/2014	MARCH	Excluded	Met	Excluded	Met
			PROV	PROV 8WST	2/4/2014	FEBRUARY	Excluded	Met	Excluded	Met
			PROV	PROV 8WST	1/17/2014	JANUARY	Excluded	Met	Excluded	Met
			PROV	PROV 8WST	3/18/2014	MARCH	Excluded	Met	Excluded	Met
			PROV	PROV 8WST	2/20/2014	FEBRUARY	Excluded	Met	Excluded	Met
			PROV	PROV 8WST	1/14/2014	JANUARY	Excluded	Not Met	Excluded	Not Met
			PROV	PROV 8WST	3/7/2014	MARCH	Excluded	Met	Excluded	Met
			PROV	PROV 8WST	3/14/2014	MARCH	Excluded	Met	Excluded	Met

Pneumonia 4.3 IPP Count Pneumonia 4.3 Totals Pneumonia 4.3 Summary Pneumonia 4.3 Detail Pneumonia 4.3 Exclusions Pneumonia 4.3 Exclusions

Improvement Process

- Identify process owner for each metric
- Send original data for review
- Identify improvement opportunities
 - coding
 - practice guidance
- Implement process standardization
- Measure compliance
- Provide departmental feedback
- Provide individual feedback

Hierarchy of Improvement Methods

1. Individual practice patterns
2. Incomplete order sets – free standing, or external guidance, available through EMR
3. Complete, fully integrated order sets
4. Order sets supported by institutional guidelines
5. Add monitoring and point of care guidance

Outpatient Services

Ambulatory and Community Health Network
Ruth M. Rothstein CORE Center
Cook County Department of Public Health

Outpatient Services – Quality of Care

Affiliate/ Indicator	CY 2013 Q2	CY 2013 Q3	CY 2013 Q4	CY 2014 Q1	2014 Target
ACHN					
% of up-to-date vaccinations in children at 24 months	68%	75%	75%	87%	72%
% of diabetics age 18-65 with at least one HgA1C in the last year	90%	91%	91%	91%	82%
% of diabetics age 18-65 with HgA1C > 9	24%	23%	23%	24%	<29%

Outpatient Services – Patient Satisfaction

Affiliate/ Indicator	CY 2013 Q2	CY 2013 Q3	CY 2013 Q4	CY 2014 Q1	2014 Target
ACHN					
Moving through the clinic visit	54%	63.4%	65.3%	66.4%	75%
Ease of getting the clinic on the phone	58.7%	59.3%	60.1%	63%	75%

Questions & Wrap Up

Cook County Health and Hospitals System
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ATTACHMENT #2

Ruth M. Rothstein CORE



June 2014 Quality and Patient Safety Committee Report

Dave Barker, MD, MPH – CORE Chief Medical Officer
Jennifer Catrambone – CORE Director of QI and Evaluation
Stephon Effinger - CORE Patient Information Coordinator
Ron Lubelchek MD – CORE Associate Medical Director

CORE Quality Plan

- Understand how our patients feel about how we serve them,
– CORE Patient Satisfaction Survey
- Evolve toward the metrics of the National HIV/AIDS Strategy
 - Treatment cascade as promoted by the CDC / IOM / CMS
 - Large scale – public health approach to HIV Care
- Ensure timely access to the services we provide
- Measure Outcomes and Processes that matter
 - HRSA / HAB / HIVQual measures
 - Primary Care Measures
- Pre-Exposure HIV Prophylaxis?
- Translational use of data to try to improve our ability to reach those at risk for HIV infection

Ruth M Rothstein CORE Center - Patient Satisfaction Survey 2009

Please think about your visits to CORE over the last 12 months when you answer these questions. Your responses will be kept private, so please be honest!

- Use a No. 2 pencil only.
- Do not use ink, ballpoint, or felt tip pens.
- Make solid marks that fill the response completely.
- Erase cleanly any marks you wish to change.
- Make no stray marks on this form.

CORRECT: ●

INCORRECT: ☑ ☒ ☓ ○

1. I have received medical care here for...

- ① less than 1 year ② 1-2 years ③ 3 to 5 years ④ more than 5 years

2. My last visit here was...

- ① less than 1 month ago ② 1-2 months ago ③ 3-6 months ago ④ more than 6 mos. ago

3. I would rate my health today as...

- ⑤ excellent ④ very good ③ good ② fair ① poor

Access to HIV Care (in the last 12 months...)

4. Did you ever call CORE to make an appointment or talk to someone about your care?

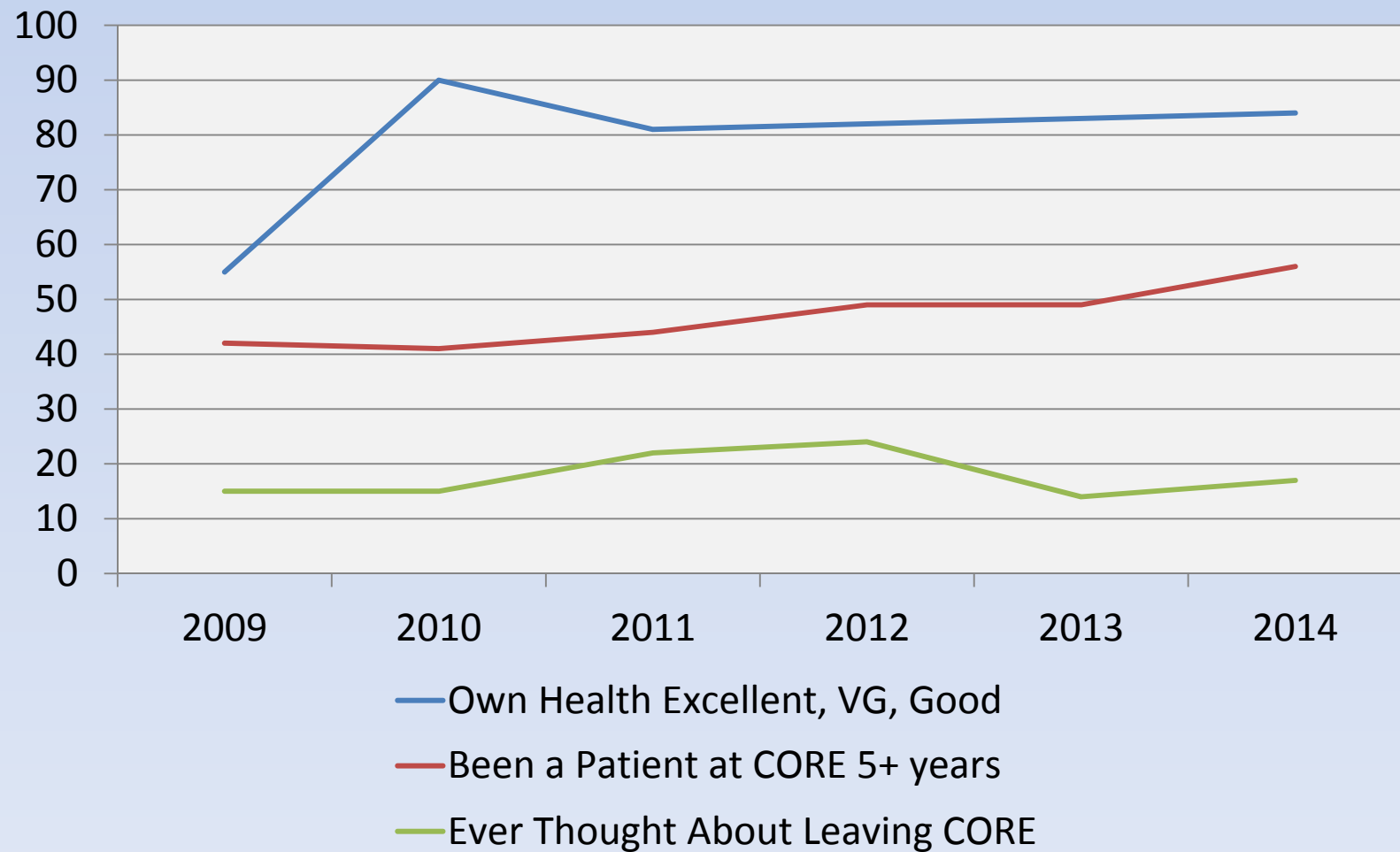
- ① yes ② no (skip to question 6)

5. If yes, what was it like when you called the clinic? (please select all that apply)

- ① I got the help I needed
② I got a busy signal
③ I was disconnected
④ I was put on hold too long
⑤ I left a message and no one called me back
⑥ I don't like to call because a machine always answers
⑦ The phone rang many times before it was answered
⑧ The person who answered the phone was unfriendly
⑨ I talked to several different people before talking to the right person

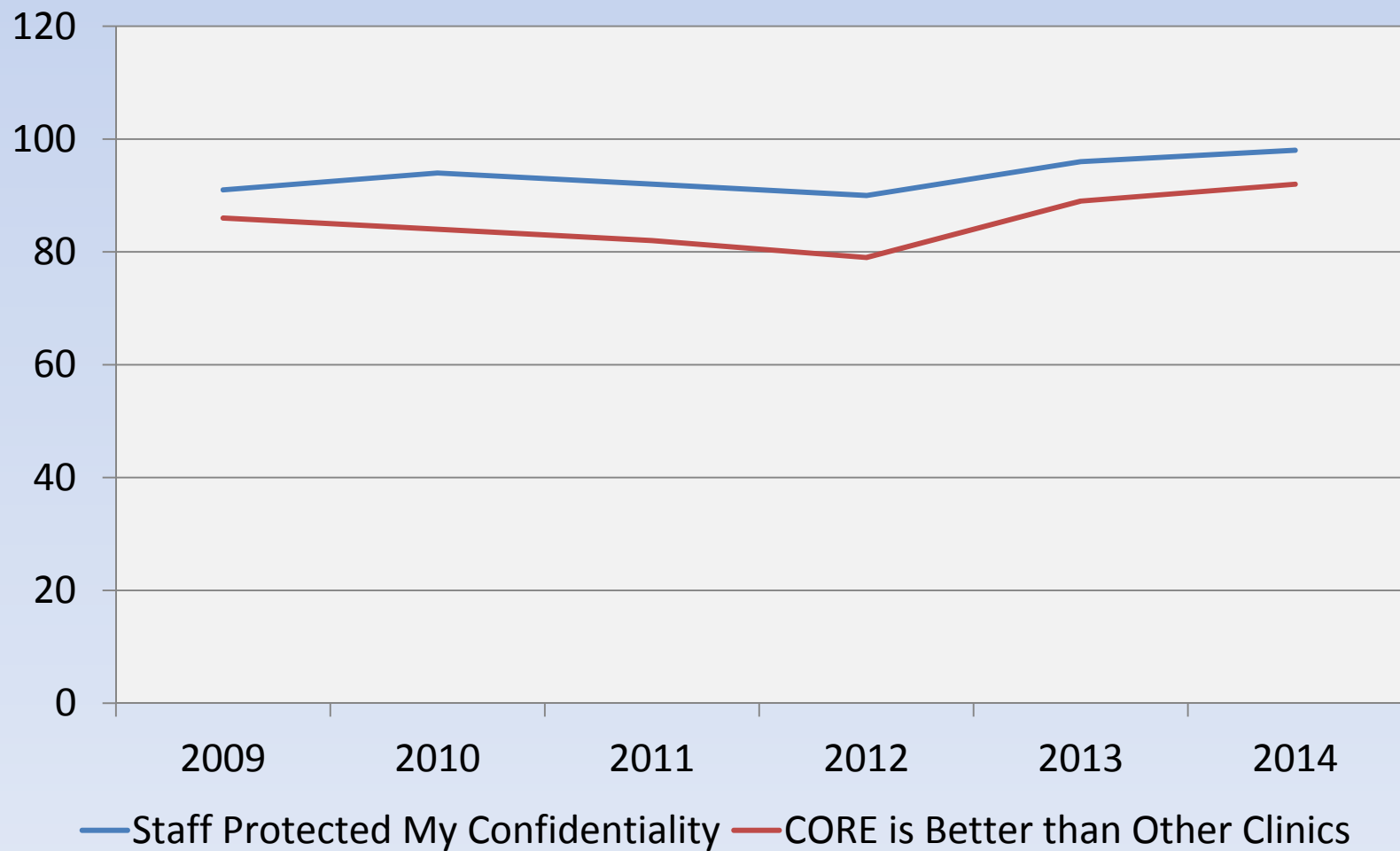
CORE Patient Satisfaction Survey – 2009 - 2014Q1

Overall



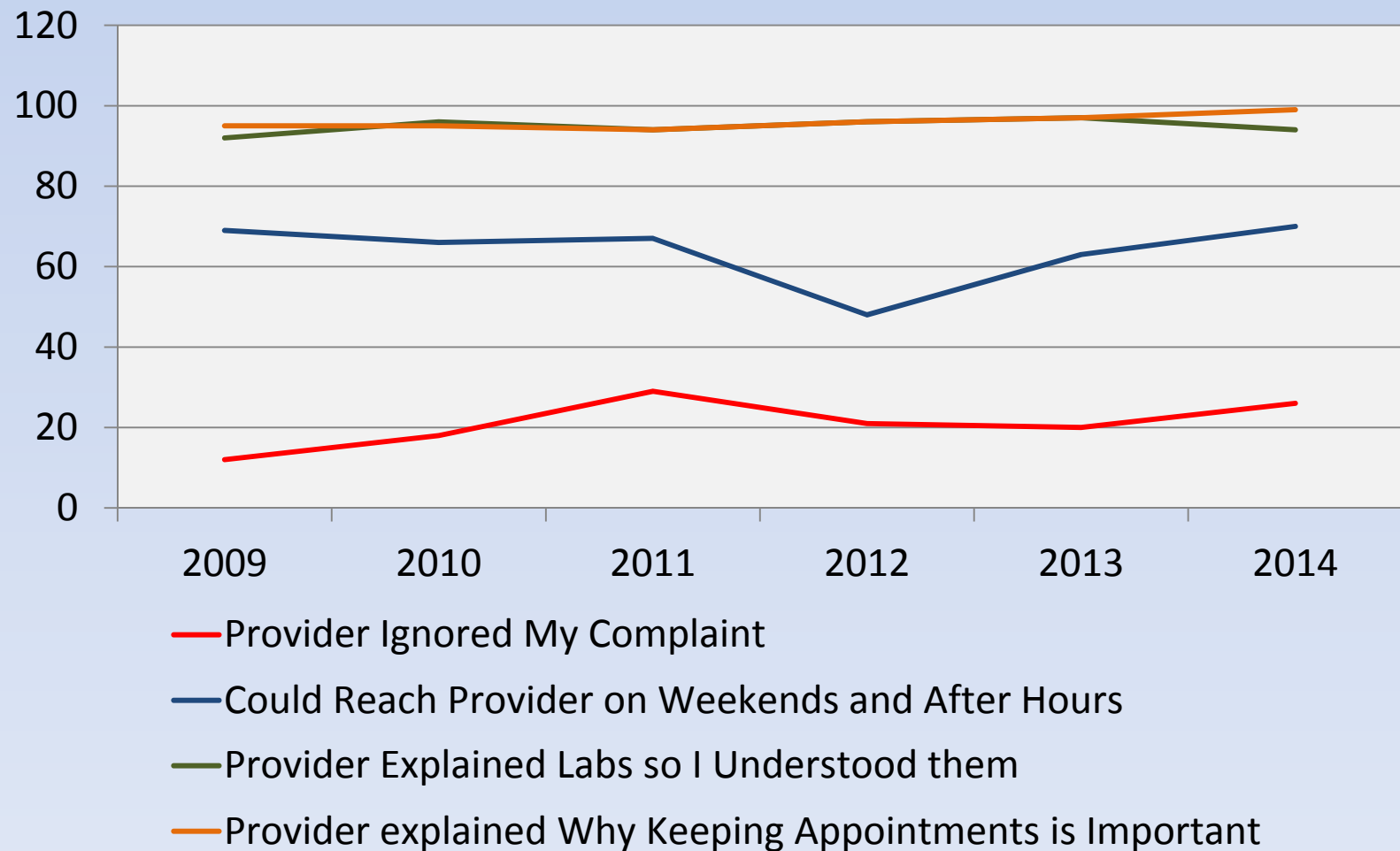
CORE Patient Satisfaction Survey – 2009 - 2014Q1

Overall



CORE Patient Satisfaction Survey – 2009 - 2014Q1

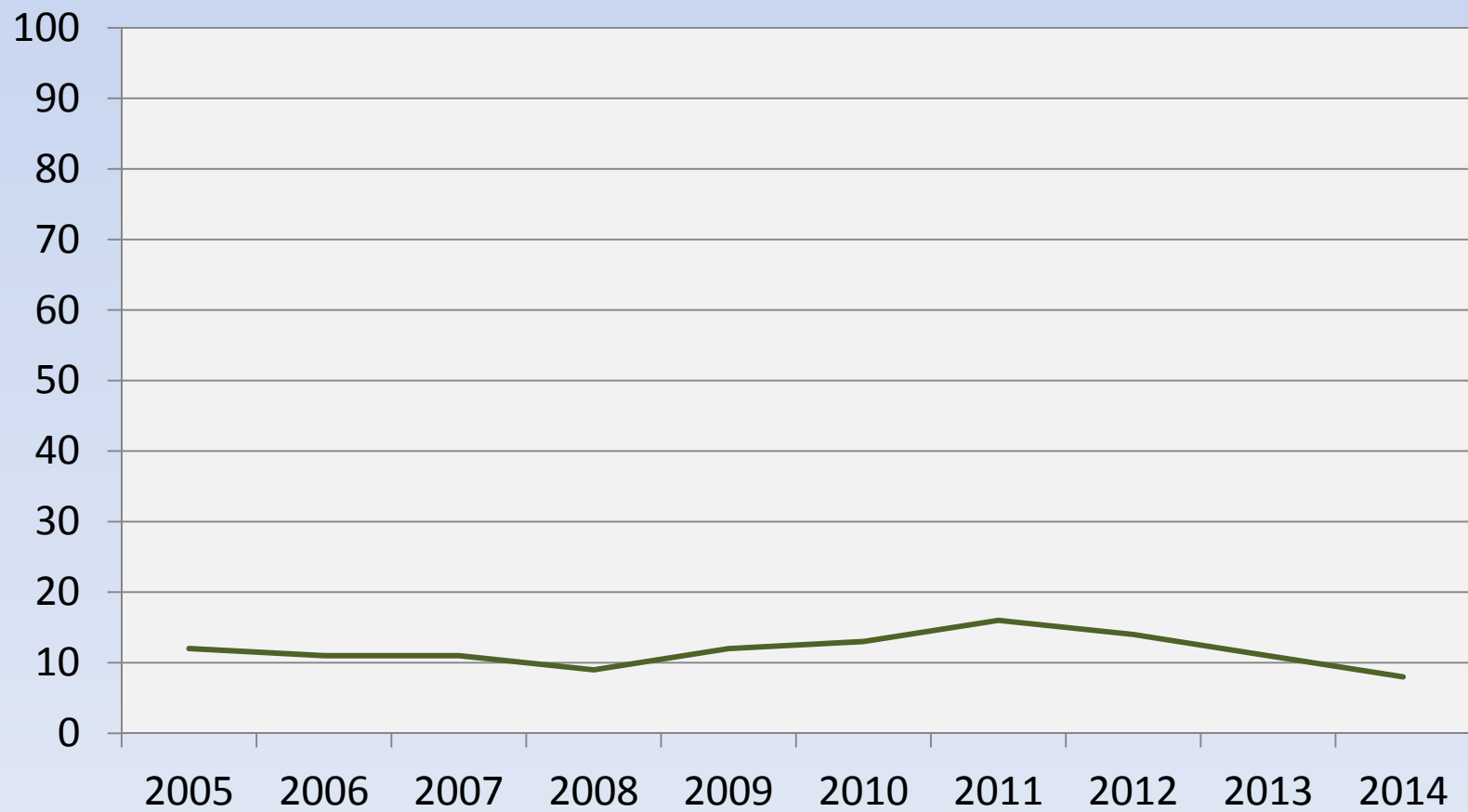
Providers



CORE Patient Satisfaction Survey – 2005 - 2014Q1

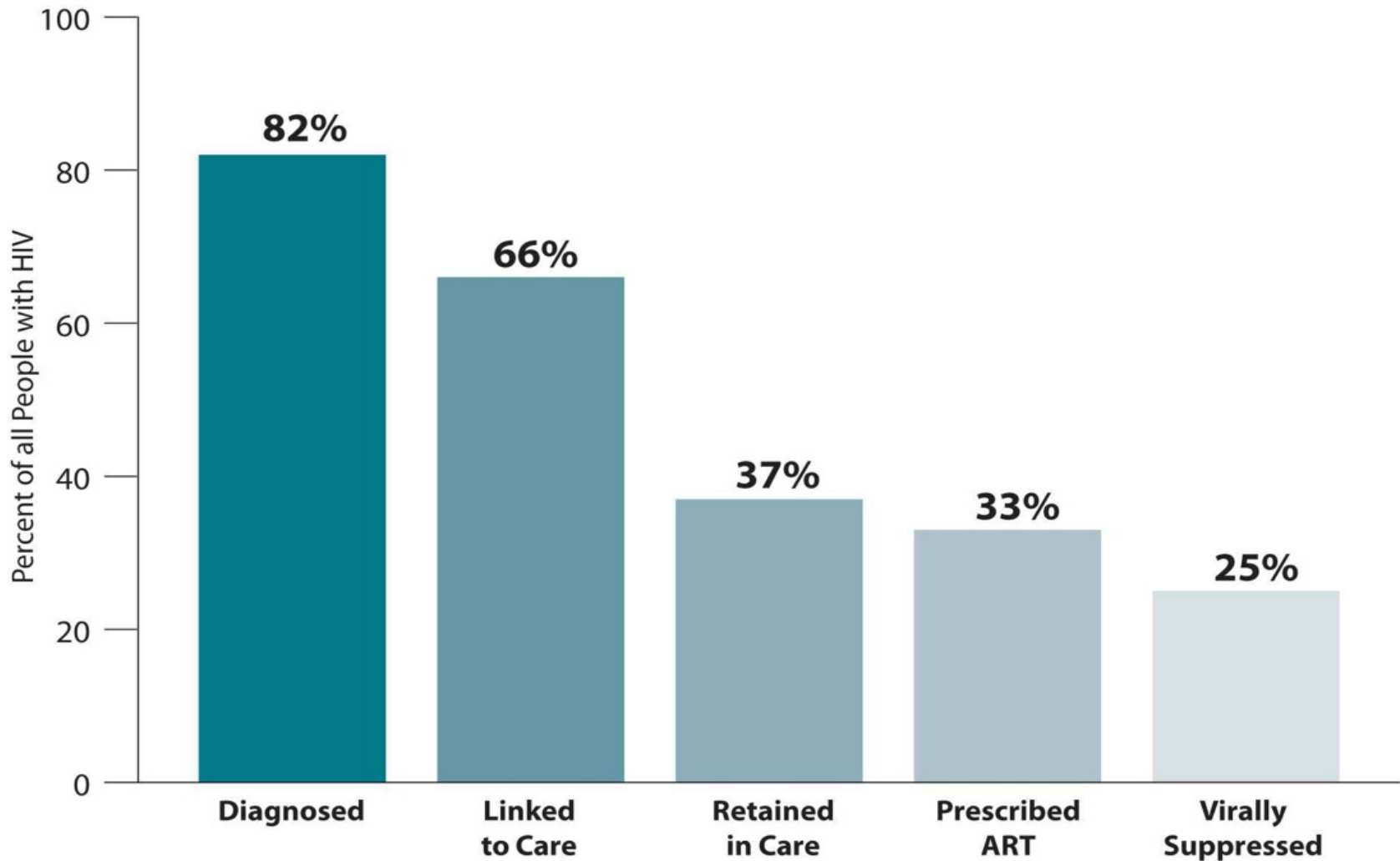
Ever Treated Poorly by Anyone at CORE in past year

% of Patients who Said Yes



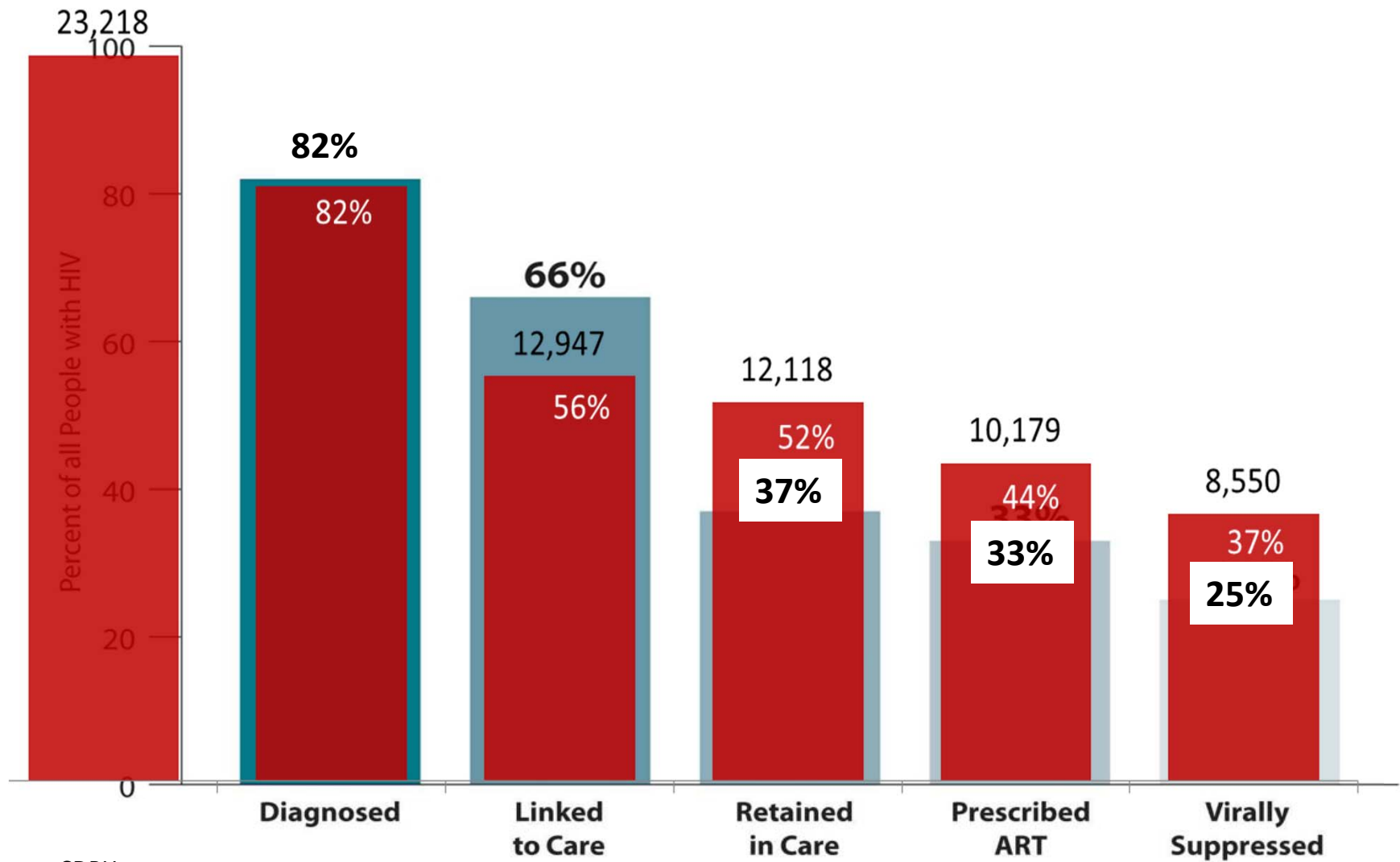
CDC HIV Treatment Cascade 2012

Entire United States



Source CDC after Gardner et al CID 2011

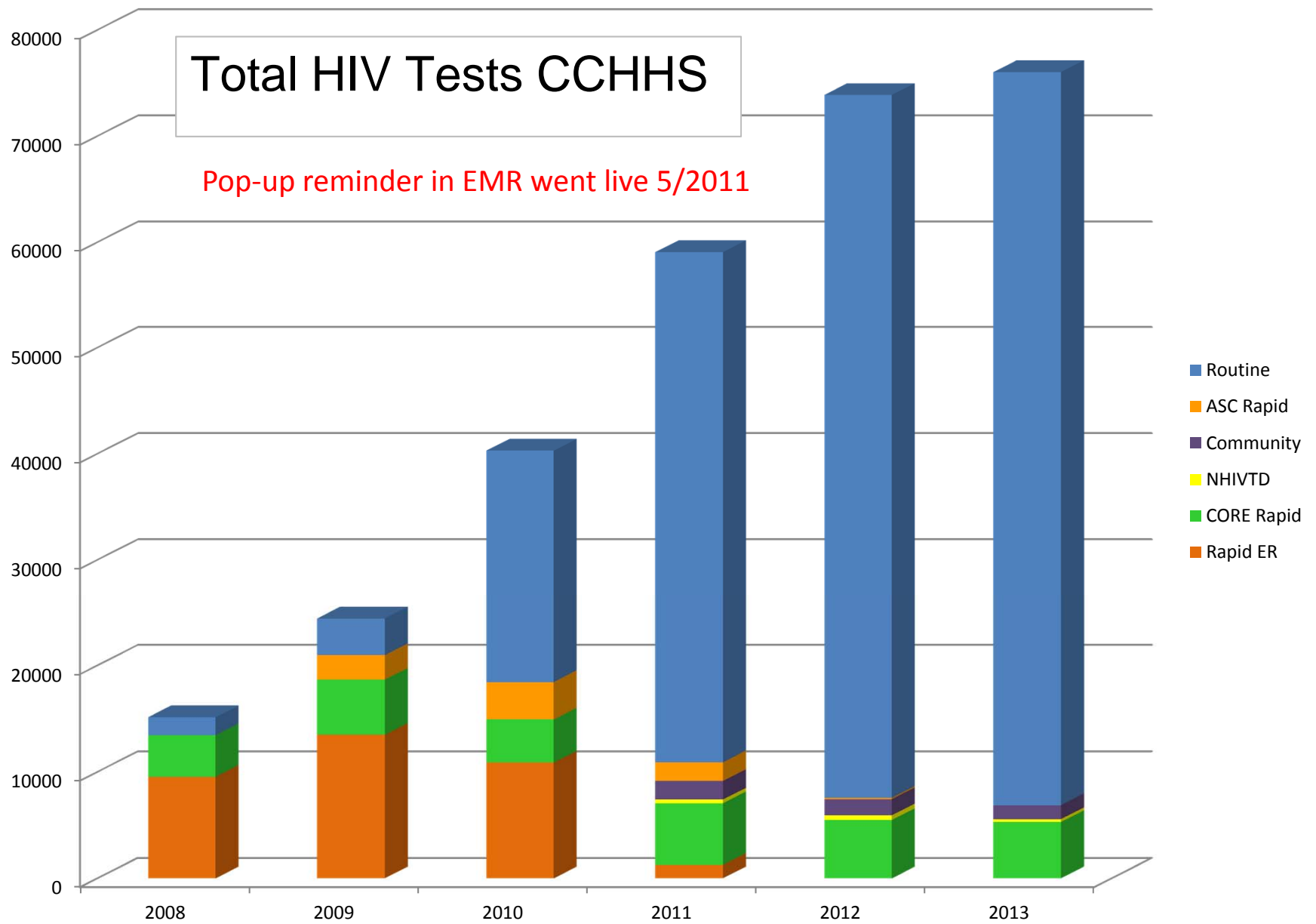
Chicago (red) 2009 overlaid on U.S. 2012



Source CDPH

Public Health Approach

- 33% of all *living* Chicagoans who have been diagnosed with HIV and nearly 50% of Chicagoans who are actively in HIV care are seen at CORE.
- Promote widespread routine testing for HIV in CCHHS
- Maintain easy Access to HIV Clinics at CORE
- Outreach to newly diagnosed, linkage to care
- Evolution to Patient Centered Medical Home to improve retention in Care
- Measure virologic suppression as community viral load and provider specific outcome.



Maintaining Early Access

Ruth M. Rothstein CORE Center - Dashboard FY 2014

Time to next new Appointment											
Service >>> Date checked <i>HIV Primary Care CORE Standard ≤10 business days</i>	1/30/2014	Business Days	1/30/2014 3rd New		4/10/2014		4/10/2014 3rd New		6/8/2014		4/10/2014 3rd New
Adult HIV Primary Care	1/31/2014	1	2/5/2014	4	4/22/2014	8	4/23/2014	10	6/17/2014	7	6/23/2014 11
Women's HIV Primary Care	1/31/2014	1	2/5/2014	4	4/11/2014	1	4/15/2014	3	6/10/2014	2	6/10/2014 2
Bilingual HIV Primary Care	2/6/2014	5	2/6/2014	5	4/14/2014	2	4/17/2014	5	6/9/2014	1	6/12/2014 4
Continuity (Correctional) Care	2/5/2014	4	2/5/2014	4	4/16/2014	4	4/16/2014	4	6/11/2014	3	6/11/2014 3
Specialty >>> Date checked <i>CORE HIV Specialty Standard <24 business days</i>	1/30/2014										
HIV Dental	4/18/2014	54	4/24/2014	58	7/10/2014	68	7/11/2014	69	9/18/2014	72	9/18/2014 72
HIV Heme Onc	2/19/2014	14	2/19/2014	14	4/16/2014	4	4/23/2014	9	6/18/2014	8	6/25/2014 13
HIV Nephrology	3/19/2014	32	3/26/2014	37	4/16/2014	4	4/23/2014	9	6/11/2014	3	6/18/2014 8
HIV Neurology	5/6/2014	66	5/13/2014	71	7/15/2014	73	7/22/2014	78	Closed		Closed
HIV OB/Gyne	2/5/2014	1	2/18/2014	11	4/15/2014	4	4/22/2014	9	6/10/2014	2	6/11/2014 3
HIV Psychiatry*	3/18/2014	31	3/19/2014	32	5/19/2014	27	5/21/2014	29	6/25/2014	13	7/2/2014 18
HIV Dermatology	3/4/2014	21	3/4/2014	21	5/13/2014	23	5/20/2014	30	7/8/2014	21	7/8/2014 21
CORE Hepatitis Clinic	2/20/2014	13	2/20/2014	13	5/8/2014	20	5/8/2014	20	8/14/2014	48	8/21/2014 53
CORE Infectious Diseases	2/11/2014	8	2/11/2014	8	4/15/2014	3	4/29/2014	13	7/1/2014	17	7/8/2014 21
OPAT IV ABX	2/6/2014	5	2/20/2014	13	5/8/2014	20	5/22/2014	30	6/12/2014	4	7/17/2014 29

Linkage to Care

- Denominator: patients who have first time confirmed HIV+ tests anywhere in CCHHS prior 3 month period
- Numerator: *of these*, patients who had a visit (not just an appointment) at a CCHHS site that provides HIV primary care
- Measure added to CORE STAR Report for 2014

Linkage to Care

- Nationally in 2012 – 66%
- Chicago in 2009 – 56%
- CORE Initial Goal for CCHHS > 60%
 - (set in December 2013)
- CCHHS March 2014 – 93%
- CCHHS April 2014 – 89%

Retained/Engaged in Care at CORE

- Denominator: all patients who have any visit at CORE in prior 12 months
- Numerator: *of these*, patients who had ≥ 2 visits at CORE >90 days apart
 - Measure added to CORE STAR Report for 2014

Retained/Engaged in Care at CORE

- Nationally in 2012 – 37%
- Chicago in 2009 – 52%
- CORE (Only) Initial Goal > 70% (set in December 2013)
– *Not comparable to cascade proportion*
- CORE December 2013 - 71%
- CORE January 2014 - 78%
- CORE February 2014 - 77%
- CORE March 2014 - 78%
- CORE April 2014 - 78%

Virologic Suppression

Community Viral Load

- Denominator: all viral load (VL) measurements at CORE during prior month
- Numerator: proportion of all VL that show reasonable virologic control
 - Measure made more stringent in CORE STAR Report for 2014 from <1,000/ml copies to <200 copies/ml to comport with IOM/CMS
- Crude but powerful overall measure of treatment efficacy (of those coming to care)

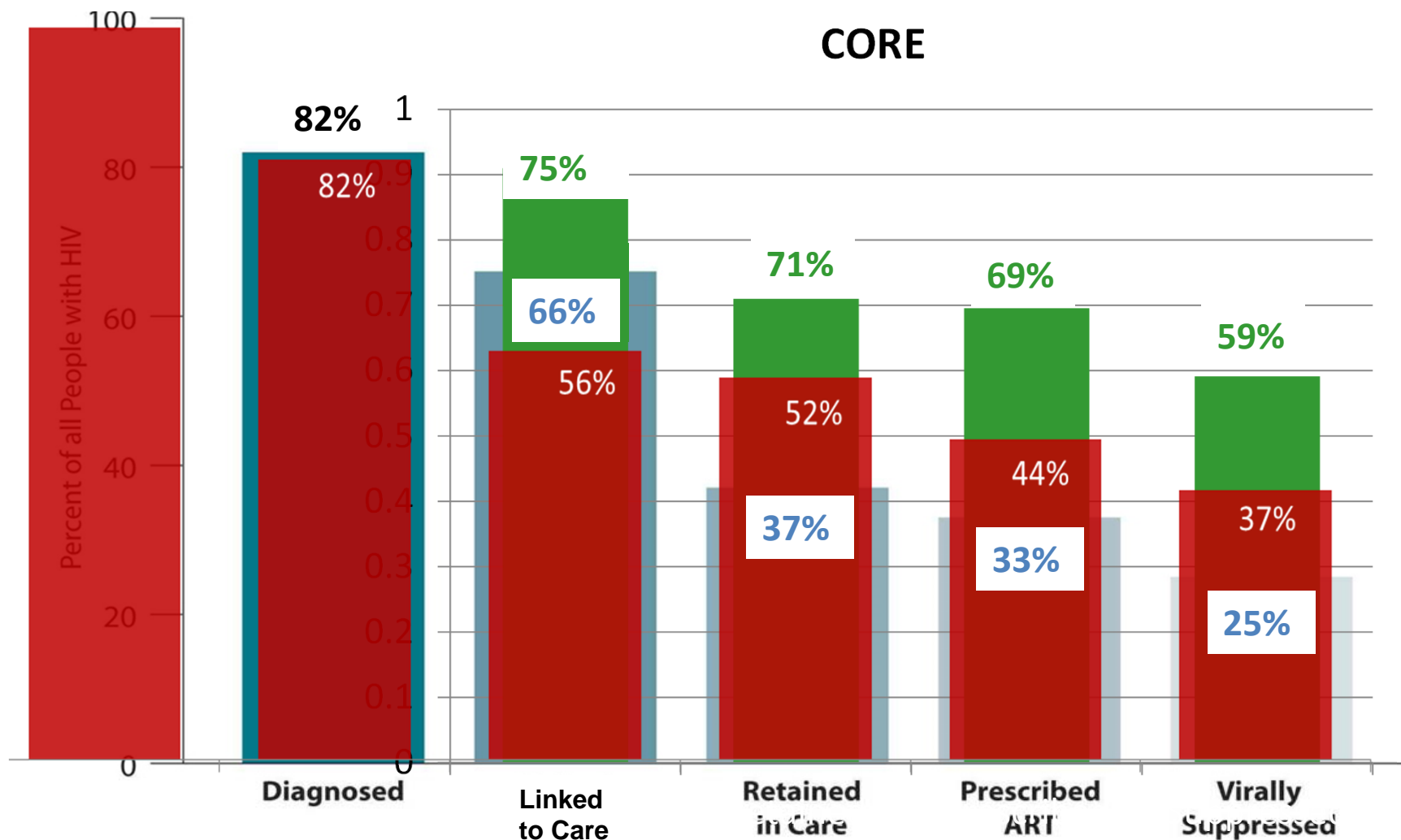
Virologic Suppression- Community Viral Load

- Nationally in 2012 – 25% (cascade all positives)
- Chicago in 2009 – 37% (cascade all positives)
- CORE Initial Goal > 70% (of those getting labs)
 - *Not comparable to cascade proportion*
- CORE December 2013 - 85%
- CORE January 2014 - 88%
- CORE February 2014 - 86%
- CORE March 2014 - 85%
- CORE April 2014 - 84%

Virologic Suppression from Another Perspective

- As a check on Community Viral Load, if we look at all the patients who are retained (engaged) in care (2 visits in prior 12 months) at CORE...
- 85% of them are less than 200 copies/ml

Chicago (red) 2009 vs U.S. (blue) 2012 CORE (green) 2014



Source CDPH

Provider summaries

- 25 measures of process and outcome
- Assesses all patients who have PCP relationship with that provider
- Given to each provider ~semi-annually
 - With comparison column for similar providers
 - With comparison column for all CORE providers
- Includes some Primary care measures –
HgBA1C

Sample Provider Summary

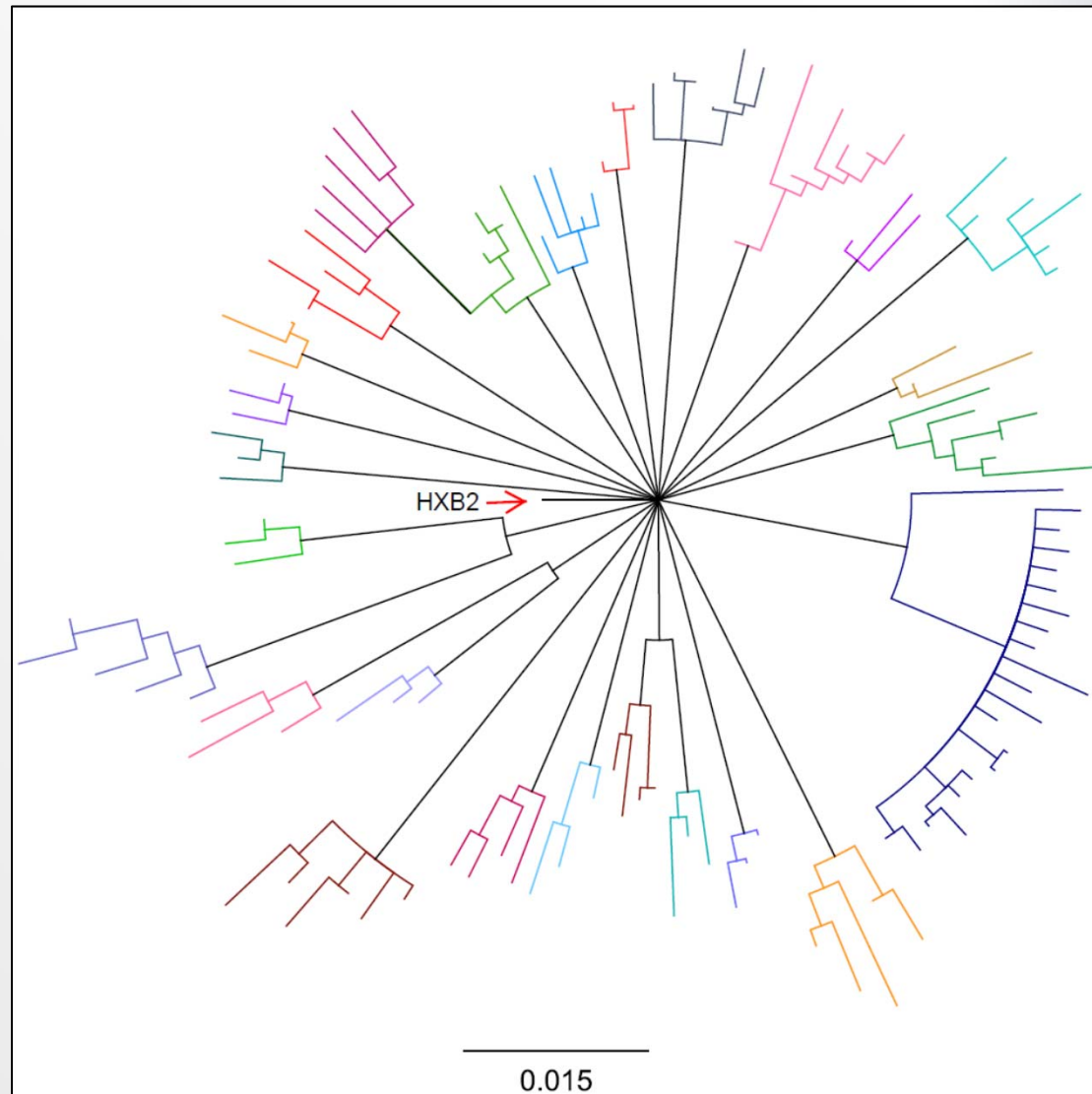
RMR CORE Center HRSA HIV/AIDS Performance Measures as of June 30, 2013									
	XXXXXXX CNP			CNP			ALL-CORE		
	num	denom	%	num	denom	%	num	denom	%
Two Primary Care Visits>= 3mos Apart %	110	157	70%	885	1201	74%	3528	5718	62%
Percentage with>=2 CD4 Counts %	98	157	62%	778	1201	65%	3230	5718	56%
Percentage with>=2 Viral Load Counts %	94	157	60%	781	1201	65%	3217	5718	56%
Viral Load Suppression (<1000 copies/mL) %	99	110	90%	814	909	90%	3234	3618	89%
Viral Load Suppression (<200 copies/mL) %	95	110	86%	774	909	85%	3076	3618	85%
Viral Load Monitoring (test performed at least every 6 mos) %	54	115	47%	522	934	56%	2042	3719	55%
Cervical Cancer Screening within last 12mos %	25	43	58%	151	398	38%	564	1636	34%
Cervical Cancer Screening within last 18mos %	28	43	65%	193	398	48%	716	1636	44%
Cervical Cancer Screening within last 24mos %	31	43	72%	224	398	56%	808	1636	49%
Hepatitis B Screening %	151	157	96%	1169	1203	97%	5165	6116	84%
Hepatitis C Screening %	148	157	94%	1153	1203	96%	5085	6125	83%
Lipid Screening %	81	137	59%	614	1047	59%	2230	4523	49%
Syphilis Screening (general population >=1 visit) %	110	157	70%	909	1201	76%	4258	6079	70%
Syphilis Screening (engaged population >=2 visits at 6mos apart) %	66	83	80%	540	660	82%	2201	2678	82%
Chlamydia Screening w/a prior STI positive screening within last 12 mos %	5	20		99	200		695	1441	
			25%			50%			48%
Chlamydia Screening (general population >=1 visit) %	19	157	12%	404	1201	34%	2013	6079	33%
Gonorrhea Screening w/a prior STI positive screening within last 12 mos %	5	20		99	200		695	1441	
			25%			50%			48%
Gonorrhea Screening (general population >=1 visit) %	19	157	12%	404	1201	34%	2013	6079	33%
HIV+ in continuous care with a CD4 count >=200 %	95	110	86%	755	885	85%	2935	3528	83%
HIV+ in continuous care with a CD4 count >=350 %	75	110	68%	577	885	65%	2216	3528	63%
Diabetics Annual A1c %	10	15	67%	80	98	82%	283	371	76%
Diabetics Annual A1c < 9 %	6	10	60%	66	80	83%	227	283	80%
Diabetics Annual Lipids Panel %	11	15	73%	71	98	72%	217	371	58%
Diabetics Annual Lipids Panel LDL < 100 (%)	9	11	82%	42	71	59%	121	217	56%

Pre-Exposure Prophylaxis - PrEP

- Giving a combination of two HIV medicines to persons at high risk to *prevent* HIV infection
 - S. Hosek PhD and J. Martinez led CCHHS PrEP studies
 - Effective at preventing infection if med taken every day
 - Risk of developing resistance becomes infected
 - Low risk of drug toxicity – requires lab tests
- CDC Recommendations for PrEP in May 2014
- Is not Cost-Effective
 - best case scenario \$330K for meds alone per case prevented, meds are ~80% of all costs
 - Limited budget for HIV meds – CORE / CCHHS will not bear cost of meds – MAP or Insurance

Translational Science

- From 2003 through 2011 CORE served as a site for CDC funded surveillance to quantify how frequently drug resistant HIV is transmitted - >12% of newly diagnosed
 - CORE accumulated >4,000 genetic sequences of newly diagnosed patients.
- In 2013 Drs. Lubelchek & Hohnen analyzed 920 of these sequences from 2009 – 2011
 - 14% of these or 124 patients had HIV that was closely related to another patient's strain
 - 26 “clusters” were identified – 3 to 21 members
 - Especially likely to be true for young, African-American, men who have sex with men



Phylogenetic tree depicting HIV patients newly diagnosed in Chicago between Jan, 2008 and May, 2011; Of 920 patients, 124, shown here, grouped into 26 transmission clusters with each tip representing an individual patient within clusters grouped by color. The scale line indicates genetic distance and the red arrow points to the out-group HXB2 reference strain

Source: Lubelchek, Hoehnen, Hotten, Kincaid, French, Barker *in press*

Intervention

- Analyze all 6,000 sequences available to us
- Add new sequences to dataset in real-time as we acquire them through clinic 200-250/year
- Where analysis reveals clustering send DIS staff to interview patients who are members of cluster and elicit sexual contacts
- Offer HIV testing to untested members of cluster
 - CORE uniquely well positioned because of large dataset available, large numbers of new patients seen each year, and high proportion of all patients in major metropolitan area in care.

Thank you

Ruth M. Rothstein
CORE



Cook County Health and Hospitals System
Quality and Patient Safety Committee Meeting Minutes
June 24, 2014

ATTACHMENT #3

John H. Stroger, Jr. Hospital of Cook County



Medical Staff and Non-Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPOINTMENT APPLICATIONS

Advani, Tushar, MD Appointment Effective:	Psychiatry/Correctional Health Services June 24, 2014 thru June 23, 2016	Active Physician
Athavale, Ambarish M., MD Appointment Effective:	Medicine/Nephrology June 24, 2014 thru June 23, 2016	Active Physician

INITIAL APPOINTMENT NON-PHYSICIAN APPLICATIONS

Hajek, Kristina N., PA-C With Ezike, Ngozi O., MD Alternate Samee, Sabiha, MD Effective	Correctional Health Svcs June 24, 2014 thru June 23, 2016	Physician Assistant
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REAPPOINTMENT APPLICATIONS

Department of Anesthesiology

Alexander, Bozana, MD Reappointment Effective:	Anesthesia July 22, 2014 thru July 21, 2016	Active Physician
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Department of Emergency Medicine

Kim, Ronald, MD Reappointment Effective:	Emergency Medicine July 20, 2014 thru July 19, 2016	Consulting Physician
Lu, Jenny Ju-Hsueh, MD Reappointment Effective:	Emergency Medicine July 22, 2014 thru July 21, 2016	Active Physician
Purim-Shem-Tov, Yanina, MD Reappointment Effective:	Emergency Medicine July 13, 2014 thru July 12, 2016	Voluntary Physician
Schindlbeck, Michael, MD Reappointment Effective:	Emergency Medicine July 22, 2014 thru July 21, 2016	Active Physician
Skoubis, Andreas, DO Reappointment Effective:	Emergency Medicine July 13, 2014 thru July 12, 2016	Services Physician

Department of Family Medicine

Billingslea, Camille, MD Reappointment Effective:	Family Medicine July 12, 2014 thru July 11, 2016	Active Physician
Cash, Crystal, MD Reappointment Effective:	Family Medicine July 20, 2014 thru July 19, 2016	Active Physician
McPherson, Julita, MD Reappointment Effective:	Family Medicine July 9, 2014 thru July 8, 2016	Active Physician

**CCHHS
APPROVED**


**BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON JUNE 24, 2014**

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications (continued)

Department of Medicine

Ansari, Najamul H., MD Reappointment Effective:	Adult Cardiology June 24, 2014 thru June 23, 2016	Voluntary Physician
Cohen, Robert A.C., MD Reappointment Effective:	Pulmonary/Critical Care July 11, 2014 thru July 10, 2016	Voluntary Physician
Lash, James, MD Reappointment Effective:	Nephrology/Hypertension June 24, 2014 thru June 23, 2016	Voluntary Physician
Manadan, Augustine, MD Reappointment Effective:	Rheumatology July 11, 2014 thru July 10, 2016	Active Physician
Maric, Nevenka, MD Reappointment Effective:	ACHN/General Medicine July 13, 2014, thru July 12, 2016	Active Physician
Martinez, Enrique, MD Reappointment Effective:	ACHN/General Medicine July 12, 2014 thru July 11, 2016	Voluntary Physician
Martinez, Irene L., MD Reappointment Effective:	General Medicine July 13, 2014 thru July 12, 2016	Voluntary Physician
Paintsil, Isaac, MD Reappointment Effective:	Hospital Medicine July 13, 2014 thru July 12, 2016	Active Physician
Peart, Malaika Y., MD Reappointment Effective:	General Medicine July 20, 2014 thru July 19, 2016	Active Physician
Pelaez, Victor M., MD Reappointment Effective:	Adult Cardiology July 11, 2014 thru July 10, 2016	Affiliate Physician
Shariff, Ruhi R., MD Reappointment Effective:	General Medicine July 13, 2014 thru July 12, 2016	Active Physician
Shim, Kyungran, MD Reappointment Effective:	General Medicine July 13, 2014 thru July 12, 2016	Active Physician
Simon, David M., MD Reappointment Effective:	Infectious Diseases July 13, 2012 thru July 12, 2016	Voluntary Physician
Smith, Jennifer G., MD Reappointment Effective:	General Medicine July 12, 2014 thru July 11, 2016	Active Physician
Smith, Patrika L., MD Reappointment Effective:	General Medicine July 13, 2014 thru July 12, 2016	Active Physician
Turbay, Rafael F., MD Reappointment Effective:	Hospital Medicine July 22, 2014 thru July 21, 2016	Active Physician
Welbel, Sharon F., MD Reappointment Effective:	Infectious Diseases July 12, 2014 thru July 11, 2016	Active Physician

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 BY THE QUALITY AND PATIENT SAFETY COMMITTEE
 ON JUNE 24, 2014



John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications (continued)

Department of Obstetrics and Gynecology

Arlandson, Mary, MD Reappointment Effective:	Ob/Gyne June 29, 2014 thru June 28, 2016	Active Physician
Swift, Eddie, MD Reappointment Effective:	Maternal Fetal Medicine June 29, 2014 thru June 28, 2016	Voluntary Physician
Ungaretti, Joy, MD Reappointment Effective:	Ob/Gyne July 13, 2014 thru July 12, 2016	Active Physician

Department of Pediatrics

Khilfeh, Manhal, MD Reappointment Effective:	Neonatology July 21, 2014 thru July 20, 2016	Active Physician
Wu-Huang, Shou-Yein, MD Reappointment Effective:	Neonatology July 20, 2014 thru July 19, 2016	Active Physician

Department of Radiology

Keen, John, MD Reappointment Effective:	Imaging Center July 22, 2014 thru July 21, 2016	Active Physician
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Department of Surgery

Dray, Philip B., MD Reappointment Effective:	Ophthalmology July 21, 2014 thru July 20, 2016	Voluntary Physician
Goldberg, Benjamin A., MD Reappointment Effective:	Orthopaedics July 22, 2014 thru July 21, 2016	Consulting Physician
Micco, Alan G., MD Reappointment Effective:	Otolaryngology July 13, 2014 thru July 12, 2016	Consulting Physician
Nichols, Jeffrey W., MD Reappointment Effective:	Ophthalmology July 13, 2014 thru July 12, 2016	Active Physician
Olivier, Mildred M.G., MD Reappointment Effective:	Ophthalmology July 13, 2014 thru July 12, 2016	Active Physician
Patel, Subhash R., MD Reappointment Effective:	Surgical Critical Care July 21, 2014 thru July 20, 2016	Voluntary Physician
Vidal, Patricia, MD Reappointment Effective:	Urology July 13, 2014 thru July 12, 2016	Active Physician

Department of Trauma

Joseph, Kimberly T., MD Reappointment Effective:	Trauma Intensive Care July 22, 2014 thru July 21, 2016	Active Physician
Messer, Thomas A., MD Reappointment Effective:	Burn Unit July 22, 2014 thru July 21, 2016	Active Physician

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BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON JUNE 24, 2014



John H. Stroger, Jr. Hospital of Cook County (continued)

Renewal of Privileges for Non-Medical Staff

Brown, Barbara J., CNP With Irons, Sharon A. MD Effective:	Medicine / General Medicine July 22, 2014 thru July 21, 2016	Nurse Practitioner
Deguzman, Jennifer P., PA-C With Smego, Douglas R., MD Alternate Ukoha, Ozuru, MD Effective:	Surgery/Cardiothoracic June 24, 2014 thru June 23, 2014	Physician Assistant

Renewal of Privileges for Non-Medical Staff (Cont'd)

Fung, Sharon D., CNS With Tulaimat, Aiman, MD Effective:	Medicine/Pulmonary & Critical Care July 20, 2014 thru July 19, 2016	Clinical Nurse Specialist
Holt, Geraldine, CNS With Fogelfeld, Leon A., MD Effective:	Medicine/Endocrinology July 22, 2014 thru July 21, 2016	Clinical Nurse Specialist
Kane-Towle, Megan R., PA-C With Bhobe, Swati S., MD Alternate Cunill, Denise R., MD Alternate Escalona, Yolanda R., DO Effective:	Pediatrics June 24, 2014 thru June 23, 2016	Physician Assistant


Medical Staff Status Change with no Change in Privileges

Adenwalla, Mohamed, MD	Surgery/Ophthalmology	From Voluntary to Consulting Physician
Ansari, Najamul H., MD	Emergency Medicine	From Active to Voluntary Physician
Giovingo, Michael, MD	Surgery/Ophthalmology	From Voluntary to Active Physician
Lamattina, Kara, MD	Surgery/Ophthalmology	From Service to Voluntary Physician
Larsen, Brian, MD	Surgery/Ophthalmology	From Voluntary to Consulting
Martinez, Enrique, MD	Medicine/ACHN	From Affiliate to Voluntary Physician
Weinstein, Robert, MD	Medicine/Infectious Diseases	From Active to Voluntary Physician

Medical Staff Additional Clinical Privileges

Marshall, Robert A., MD	Mammography Reading
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APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON JUNE 24, 2014





Provident Hospital of Cook County

Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

REAPPOINTMENT APPLICATIONS


Department of Family Medicine

Billingslea, Camille, MD Reappointment Effective:	Family Medicine July 12, 2014 thru July 11, 2016	Active Physician
McPherson, Julita, MD Reappointment Effective:	Family Medicine July 8, 2014 thru July 7, 2016	Active Physician

Department of Surgery

Dwarkanathan, Surendar, MD Reappointment Effective:	Ophthalmology June 24, 2014 thru May 16, 2016	Affiliate Physician
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CCHHS
APPROVED
BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON JUNE 24, 2014

A handwritten signature in black ink, appearing to be a stylized "S" or "J", is written over the word "COMMITTEE" in the approval stamp.